Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: SIERRA MEDICAL CENTER PO BOX 809053 DALLAS TX 75380-9053	MFDR Tracking #:	M4-03-6846-01
Respondent Name and Box #: Travelers Indemnity Co. of Connecticut Box #: 05		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Carrier paid most charges at 92 to 99 % upon appeal. These two charges were paid at TWCC Fee Guidelines. TWCC Rule 134.401(a)(3) states 'Services such as outpatient physical therapy, radiological studies, and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services.' We request only 75% of billed charges as a fair and reasonable amount."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $134.37
3. Hospital Bill
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No response received from the carrier.

Principle Documentation: None

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
5/27/2002	1, 2	87186	$72.06	$0.00
5/27/2002	1, 2	87184	$62.31	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - 1 – "The charge exceeds usual and customary. (Z601)"
   - 2 – "Reviewed : 12/06/02 / Original Control #: 04023122520800
     Original Total Recommended Amt: $59.00 / Invoice #:"
2. This dispute relates to outpatient laboratory studies performed in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(a)(3), effective August 1, 1997, 22 TexReg 6264, which provides that such services shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services.

3. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011"…

4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records"… This request for medical fee dispute resolution was received by the Division on May 9, 2003. Pursuant to §133.307(g)(3), the Division notified the requestor on May 28, 2003 to send the additional required documentation. Review of the submitted evidence finds that the requestor has not sent a copy of any pertinent medical records. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(B).

6. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement"… The requestor's rationale for increased reimbursement from the *Table of Disputed Services* states that "We request only 75% of billed charges as a fair and reasonable amount." However, the requestor does not explain how payment of 75% of billed charges would result in a fair and reasonable reimbursement for the services in dispute. The requestor did not submit convincing evidence to support the rationale for increased reimbursement. The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the statutory requirements and Division rules. The request for additional reimbursement is not supported.

7. Additionally, the Division has determined that a reimbursement methodology based upon a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that:

   > "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

   Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment in the amount sought by the requestor would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rule at 28 Texas Administrative Code §133.307(g)(3)(B) and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.